KEY ELEMENTS OF A

FAMILY SUPPORT/CASE MANAGEMENT MODEL

PREPARED FOR THE

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

TORONTO, ONTARIO

JANUARY, 1982

Supported by the Ministry's Provincial Lottery Fund

The Applied Research Consulting House Ltd.
2021 Cliff Road, Mississauga, Ontario L5A 3N7 (416) 273-4098

TABLE OF CONTENTS

		Page
	ACKNOWLEDGEMENTS	i
	EXECUTIVE SUMMARY	ii-iv
I.	BACKGROUND AND PURPOSE	1
II.	RATIONALE FOR CASE COORDINATION/MANAGEMENT	1
III.	GOALS AND OBJECTIVES OF A CASE MANAGEMENT SYSTEM	3
IV.	FUNCTIONS OF A CASE MANAGEMENT SYSTEM	4
	Assessment	6
	Developing a Plan	7
	Arranging for Service Delivery	8
	Monitoring Service Delivery	11
	Evaluation and Follow-up	12
V.	SOME STRUCTURAL CONSIDERATIONS REGARDING IMPLEMENTATION	13
	Systems Support	13
	Case Manager or Team Case Management	14
	Supervision	15
	Caseload	15
	Selection and Training of Case Managers	16
VI.	APPLICABILITY OF A CASE MANAGEMENT MODEL	17
	Impact of Case Management Systems	17
	Dimensions to Consider	19
	Expanding the Case Management Potential of Children's Services	22
VII.	REFERENCES	27

ACKNOWLEDGEMENTS

The preparation of this document was very much a team effort. Thanks are due to Jane Edmunds-Barken, Peter Clutterbuck and Peter Turner for their contributions.

Thanks are also due to Dr. Aldred Neufeldt for his helpful comments on a draft of the manuscript.

The final document benefited from the input of the Ministry appointed Advisory Committee to the project, and their ongoing assistance was greatly appreciated.

Final responsibility for the contents of this document is my own.

Jack Santa-Barbara, Ph.D.
President
The Applied Research Consulting House Ltd.

EXECUTIVE SUMMARY

The key elements of a case management model are identified as:.

A. An explicit, well-publicized ideological base for the program, which includes a commitment to the following principles:

   1. Comprehensive, coordinated services;

   2. Continuity of service over time;

   3. Accessibility to generic services as much as possible, and to multiple, specialized services as required;

   4. Accountability within the service system, generally vested in an individual;

   5. Efficient use of available resources and the development of new services as needed;

   6. Individualized service plans;

   7. Developmental orientation toward self-sufficiency;

   8. Community-based services;

   9. Client involvement in the decision-making process;

   10. Client advocacy; and,

   11. Systems advocacy.

B. Systems supports for the case management role via:

   1. Long-term government commitment;

   2. Extensive publicity;

3. An explicit mandate and authority (through legislation or guidelines);

4. Explicit policy and procedures;

5. Liaison across all Ministries dealing with human services; and,

6. Clear lines of authority and responsibility extending from ideology to the field (e.g. via core agencies).

C. Case Management functions may be summarized as:

1. Comprehensive human needs assessment which at a minimum focuses on a range of basic needs such as housing, food, employment, health, etc.;

2. Service planning based on needs identified, with consumer involvement;

3. Linking clients with appropriate services;

4. Monitoring client status and/or the services provided; and,

5. Evaluation and follow-up of the services provided.

D. There are many variants of each of these basic functions. There is no one best model for all circumstances. The precise form a case management model takes will depend on:

1. Client characteristics, such as:
   - potential for self help
   - multiplicity of needs
   - crisis proneness
   - degree of motivation for services; and,

2. Service delivery characteristics, such as:
   - the availability of services
   - the distribution/concentration of specialized and general services
   - the professionalism inherent in the services.

E. Possible directions for expanding the case management potential of Children's Services in Ontario include:

1. Publicity about the role of case management;

2. Systems support for case management (e.g. through regional offices);

3. An expansion of existing case management type roles (e.g. prime workers in residential settings, probation and aftercare officers) to areas where they do not currently exist;

4. Identification of "core agencies";

5. Publication of general policies and guidelines for case management, including both case and systems advocacy;

6. The development of inter-ministerial policy regarding human services;

7. The development and utilization of a comprehensive human services needs assessment framework;

8. The identification of specific individuals as responsible for case management at each level of the system; and,

9. The development of a training program for case managers/advocates.

I. BACKGROUND AND PURPOSE

This paper is part of a project entitled "Evaluation of Family Support Worker Models" and is based on an integration of the other components of this project, namely:

- a review of the literature on family support worker concepts, programs and evaluations
- site visits to some case management programs in Ontario
- the "Evaluation Report: Ontario Family Support Worker Program" (Applied Research Consulting House, 1982) which reviewed seven programs currently operating in Ontario

The purpose of this paper is to identify the key elements of a family support/case management model and to discuss the applicability of such a model for a broad range of children's services.

II. RATIONALE FOR CASE COORDINATION/MANAGEMENT

In discussing case management models, it is helpful to identify the reasons why such a model has evolved in several jurisdictions over the past two decades. First of all, human services are generally characterized as being fragmented (Intagliata, in press; Gans and Horton, 1975; Levine, 1979), with each agency providing a specialized service. Because there are generally more clients in need of human services than can be served by existing resources, agencies are generally non-competitive in terms of "marketing" themselves to clients. The onus is on the client to identify and obtain the appropriate service. However, this process of obtaining the appropriate service is difficult enough even for the intelligent, healthy consumer (Pratt, 1976). For individuals who are disabled in some way, or who are not motivated to obtaining needed services for themselves or their

families, the process is often extremely difficult. The deinstitutionalization which has occurred over the past two decades has added greatly to the number of disabled individuals in the community who continue to require ongoing and diverse services (Test, 1979).

As a result of these conditions, clients frequently experience frustration and discontinuity when they encounter the service system. Clients initially lack knowledge about where to go for what types of assistance. Faced with a variety of client demands, many agencies respond by expanding their range of services (often unofficially), leading to either a duplication of services with existing or other expanding agencies, or an inappropriate use of costly professional expertise, or both. This leads to a blurring of roles for both the client and the professional, and impedes the efficient delivery of human services to clients in need. When clients with multiple problems obtain various services from a number of different agencies, these agencies are often unaware of each other's involvement. Consequently, these multiple services remain uncoordinated, and no single service provider is identified as the party responsible for such coordination. The quality of care in such a system is often seriously jeopardized (General Accounting Office, 1976; Bassuk and Gerson, 1978; Willer, et al, 1978).

The acknowledgement of this "systems mess" (Rae-Grant, 1976) accounts for the interest in and development of service coordination systems in many jurisdictions, with case management being a key component of many.

Case management systems, therefore, are seen as solutions which can:

- provide cost-efficient service delivery,
- assist clients in obtaining the appropriate services they need, and
- protect costly specialized services from providing more general support services required by clients.

These fiscal, humanistic and systems management motives vary from jurisdiction to jurisdiction, but are generally present in each attempt at case management.

III. GOALS AND OBJECTIVES OF A CASE MANAGEMENT SYSTEM

The ideologies and value systems that are associated with various case management systems overlap considerably with each other and with the "Program Priorities for Children's Services in 1978", identified by the Ontario Ministry of Community and Social Services. Intagliata (in press) summarizes the most fundamental goals of the case management effort as:

1. enhancing the continuity of care, regarding both the comprehensiveness and coordination of services, as well as continuity over a longitudinal perspective;

2. increasing accessibility to the multiple, specialized services available in a community;

3. increasing the accountability within the service system by designating a single person or agency as responsible for the overall effect of the system; and,

4. enhancing the efficiency of service delivery in the system, by assuring that clients receive the services they require and are entitled to, and that they are received when they are needed.

Other principles of case management which have been articulated include (after Rehab Group Inc., 1980):

5. a respect for the client's dignity;

6. a focus on meeting all the client's needs (comprehensiveness);

7. a focus on the uniqueness of each client's individualized needs;

8. a focus on community-based services which follow the principles of: least restrictive alternatives, minimal intervention, family support;

9. an awareness of the importance of keeping client dependency to a minimum by encouraging self-sufficiency and involving the client in the decision-making process.

IV. FUNCTIONS OF A CASE MANAGEMENT SYSTEM

The above goals and objectives may be operationalized in a variety of ways. The most basic functions of a case management process (Agranoff, 1977) are those identified as the characteristics of the Mental Retardation Family Support Worker Program in Ontario (Ministry of Community and Social Services, 1978), namely:

1. the assessment of client need;
2. the development of a comprehensive service plan;
3. the arrangement for the services to be provided;
4. the monitoring of the services delivered; and,
5. evaluation and follow-up.

While these five functions are included in almost all case management descriptions, other models are more expansive. Two more inclusive lists of functions are presented in Table 1. The additional functions which appear most often are outreach, direct service provision (support and crisis intervention) and advocacy at both the individual and system levels.

The most important point about this basic and expanded list of functions is that a case management system must be tailored to meet the particular characteristics of the situation in which it must function. This will be discussed below (VI. Applicability).

TABLE 1

PROPOSED CASE MANAGEMENT FUNCTIONS*

	GOVERNOR'S INTERAGENCY TASK FORCE (1979)		
1.	Outreach/client identification	1.	Outreach
2.	Determining eligibility	2.	Assessment
3.	Assessing client needs	3.	Case planning
4.	Planning with client	4.	Referrals
5.	Authorizing services	5.	Client advocacy
6.	Linking	6.	Direct casework
7.	Monitoring	7.	Building client's natural support system
8.	Coordination	8.	Reassessment
9.	Advocacy	9.	Service advocacy
10.	Problem-solving/goal setting	10.	Monitoring quality
11.	Helping and supporting	11.	Public education
12.	Resource identification	12.	Crisis intervention
13.	Resource development		
14.	Record keeping		
15.	Providing missing life management supports		
16.	Termination		

* From Intagliata (in press).

It is also interesting to note the absence of a very simple yet important coordinating function, which was evident in some of the community-oriented Family Support Worker programs reviewed (Applied Research Consulting House, 1982) -- the provision of information to both client and community agencies about services available.

Although the five basic functions listed above are shared by all case management systems, they are expressed in very different ways in various systems. It is helpful to consider the different interpretations of these functions, as they can greatly alter the form of a case management system. It should be noted that the various interpretations of any one of these functions cannot be judged in isolation from the interpretations of other functions in the same system. Ultimately, it is the overall system which must account for whether the goals of case management are achieved.

Assessment

The assessment function in case management systems may include:

1. An ad hoc assessment of needs as defined by the client, where there is no systematic use of a comprehensive framework. This was the situation in the majority of Family Support Worker programs reviewed (Applied Research Consulting House, 1982) and is felt to be inadequate.

2. The gathering of assessment information from other agencies with which the client is, or has been, involved. If this is done without systematic reference to a comprehensive framework, it will be of limited value. If the information is gathered and referred to a systematic framework of some sort, then any incompleteness in the assessment data will be readily apparent.

3. A systematic assessment by the case manager, using a comprehensive human service needs framework.

4. An assessment conducted by a fully resourced assessment unit, with which the case manager is affiliated in some way. This type of comprehensive assessment is conducted at the Clinical Institute of the Addiction Research Foundation in Toronto.

To be sure, there are futher variants of the assessment function. Those listed indicate the range of interpretations that are given to this function, and which interpretation is appropriate will, of course, depend upon the circumstances of the entire system. It is important to note that some assessment procedures focus on a comprehensive human needs assessment, as distinct from a specialized clinical assessment. The former focuses on a wide range of basic human needs such as housing, health, employment, food, etc. Several such comprehensive frameworks are currently in use (e.g. Sullivan, undated; Department of Human Resources, 1974; John, 1977; MacCoy, undated; Division of Mental Retardation, 1980).

Developing a Plan

This function is at the heart of the coordinating process, yet has many interpretations. This includes the performance by the case manager of various activities, such as:

1. deciding what services the client requires based on his/her understanding of the assessment information;

2. developing an Individualized Program Plan (IPP), or Treatment Plan (ITP), which may or may not involve the client and/or the agencies included in the plan. These plans may focus only on short-term needs of the client, or may integrate both short and long-term goals into a comprehensive plan. Ideally, such plans become a focal mechanism for monitoring and reviewing cases, as well as initiating a program;

3. making a formal (written) contract with the client and/or service agencies;

4. arranging a case conference among the service providers involved, with or without the client present; and,

5. arranging for some professional body to develop a plan.

Obviously, these interpretations of developing a plan may overlap to varying degrees. An important impact of this function is that it initiates a dynamic, interactive process by getting all relevant parties together. Again, the total system must be considered to determine which interpretation of this planning function is most appropriate.

Arranging for Service Delivery (Coordinating Services)

Once the plan has been developed, it must be carried out. This may be accomplished by the case manager:

1. encouraging the client to arrange his/her own contact and contracts with the service providers (gives information and encouragement);

2. making the necessary arrangements with the service providers <u>with</u> the client (supports and provides a model for the client);

3. making the necessary arrangements with the service providers <u>for</u> the client (makes a referral); and,

4. taking the client into a service operated directly by the case manager's agency (service provision).

The particular approach will depend upon the authority base or mandate of the case manager, which may include:

1. personal persuasion - which will vary not only with the personal characteristics of the case manager, but also with his/her status and credibility in the case manager role;

2. the case manager's knowledge, and resources to access various services;

3. legislative authority or guidelines to require certain agencies to provide particular services to particular clients;

4. the use of discretionary funds to purchase the services required; and,

5. advocacy on behalf of clients for services, or access to services, not available to them.

Several authors (e.g. Mittenthal, 1976; Ross, 1980) have identified the need for the case manager to have some authority over and above their personal influence. It has also been deemed essential that the case manager's role be supplemented with "formal structures for assuring coordination and linkages of services on a systems level" (Intagliata, in press).

In several U.S. programs (e.g. Turner and Shiffren, 1979; Lippman, 1976), these systems linkages have been enacted through a "core agency". This is an agency in a geographic planning area which has the responsibility and authority to coordinate services within that region. Such core agencies also have the role of developing new services, if gaps are identified by case managers when client plans are being developed. In Ontario, the development of the local Children's Services Committees might play such a leadership role.

The advocacy function which is part of so many case management systems, may be carried out in a variety of ways. Many authors (e.g. Intagliata, in press) acknowledge that the case manager is not the only individual in the service system with an advocacy role. All professionals in the service delivery system should be client advocates to some extent and, indeed, others such as client associations and community groups also play an important advocacy role. However, because of this widespread responsibility for advocacy, the advocacy role may become quite diffuse

and unclear. Because it is everyone's responsibility, no one may take the initiative. This is particularly true in a situation where a professional's view of what a client requires would embarass the agency which employs him or her (Patti, 1974; Richan, 1973). In this situation of mixed loyalties, it is traditionally the agency which wins out (Jessing and Dean, 1977).

While officially legitimizing the internal advocate role may reduce the potential conflict of interests, it will not eliminate the problem. Several jurisdictions (e.g. Developmental Disabilities Assistance and Bill of Rights Act of 1975) have defined the advocate role as one which must be free of any service delivery agency, so that the advocacy function may be pursued vigorously, through both administrative and legal means if necessary.

While many advocacy issues related to individual clients may be resolved by case managers through personal negotiation (Riffer and Freedman, 1980), class or systems advocacy requires the involvement of a systems coordination structure. This structure must be empowered to develop new services in a coordinated fashion. In the evaluation of the Mental Retardation Family Support Worker Program (Applied Research Consulting House, 1982), some case managers complained that the only community committees they were on consisted solely of mental retardation agencies and, therefore, hampered their attempts to integrate services for their clients with generic agencies.

In addition to these functions of assuring that clients are linked with services, the case manager's role may extend even further. As the single person to whom a client may turn, the case manager must be prepared to provide a wide range of support services to "plug the dike", as needs arise (Turner and Shiffren, 1979). These support services may involve assistance with problems of daily living, or crisis intervention. The extent to which the case manager can quickly link clients to other services to meet these types of needs, will have a large bearing on the case manager's caseload. Such support services are essential and in most case management systems are provided by the case manager in the first instance. As indicated by one

of the workers in the Mental Retardation Family Support Worker Project, "The buck stops here". This means that the case manager must be a professional generalist (Intagliata, 1978).

Monitoring Service Delivery

Once provisions have been made for carrying out a service plan, the case manager has the responsibility of monitoring whether the services are meeting the clients' needs, or whether the needs have changed. Some monitoring procedures focus exclusively on client status, while other monitoring systems allow the case managers to review the quality of the services provided. In different systems, either of these procedures may be accomplished in different ways, including:

1. the periodic review of IPPs, or ITPS;

2. case conferences with relevant service providers, with or without clients present;

3. frequent contact with the client, to reassess needs and to determine if the service plan is meeting those needs;

4. responding to client requests for assistance in meeting new needs, or in dealing with a service provider; and,

5. applying sanctions against service providers who are not meeting their obligations.

A major issue which distinguishes one type of case management from another is whether the case manager actually has the authority to alter services provided by an agency (Report of a U.S. Study Team, 1974; Human Ecology Institute, 1975; Washington, 1979; and John, 1974). This authority is viewed as essential by some (Gans and Horton, 1975; Intagliata, in press). In some jurisdictions, the case manager may not have the authority to

directly exercise any quality control on the service provider, but they do have the legitimacy to review services, and to communicate their findings to relevant decision makers.

In the Mental Retardation Family Support Program, there was not a clear mandate for the case manager to review the services being coordinated. Case managers would become aware of client difficulties either through informal contact with the client, or through additional requests from the client. To a person, the family support workers did not wish to have such authority, fearing it would jeopardize their relationship with service providers with whom they had to negotiate. This type of function may hamper the advocacy role of the case manager -- at both the individual and systems levels.

Some family support programs did attempt periodic monitoring of client status, but this was rare. In our visits to case management programs other than Family Support Workers, we found one program that did engage in a fairly systematic and extended monitoring process. They would initiate contact with clients on a pre-set schedule up to 18 months, or longer, if required.

Evaluation and Follow-Up

This activity is a natural extension of the monitoring function, and is similar in form, except that it occurs after a client is no longer receiving services. Case management systems vary considerably with respect to the frequency and intensity of follow-up activity. In the interests of being non-intrusive, some case managers simply inform the clients that they are available should any needs arise. Others engage in more outreach, themselves initiating contact with former clients on a routine basis, or when they hear from some source that the client might benefit from some contact.

The type of follow-up should ideally be determined by the likelihood of the client requiring additional services, and of needing assistance to obtain it. While the goal of most case management systems is to assist clients to be independent consumers of services, there is the realization that this may not be a realistic expectation for some clients. If such clients are also at high risk for recidivism, then more systematic follow-up would be desirable.

Few case management programs systematically gather data on their own operations. Although there have been several evaluations of case management programs, these have generally been external evaluations. Formative evaluations conducted internally, which relate directly to the planning and development of case management systems, are a rare occurrence. This is unfortunate, as there is still much to be learned about the design and functioning of a case management system, and this type of formative evaluation could make a significant contribution.

V. SOME STRUCTURAL CONSIDERATIONS REGARDING IMPLEMENTATION

In addition to considering the various functions of a case management system, it is also helpful to reflect on several structural considerations.

Systems Support

The overall system must support the program administratively, legislatively and politically. If case managers are to maximize their advocacy potential, they require clear and direct linkages with the planning and service development authority of the region (Intagliata, in press; Washington, 1974). Case managers require a clear, explicit and well publicized mandate from the system planners and developers. While case managers are the heart of a

coordination system, they cannot be expected to reorganize a "systems mess" (Rae-Grant, 1976) on their own, solely at the client level. The systems problems that have evolved over time will require a long-term commitment on the part of government to rectify the situation (Amadio, 1976). If a program or project is seen as "experimental", the commitments of agencies and professionals will likely be guarded (Gans and Horton, 1975).

A particularly important form of systems support for case managers is the availability of explicit policies and operational procedures regulating their activities. These elements were lacking in the Mental Retardation Family Support Program, leading to great diversity in orientation and procedures when interpreting the basic case management functions. While flexibility at the local level is a necessity, some uniformity of the basic functions must be maintained if a program is to have a clear identity and role among the agencies it is to coordinate.

Case Manager or Team Case Management

In most systems, the various functions outlined above have been the responsibility of a single individual -- the case manager. However, in some programs, the approach has been to develop a case management team (Gittelman, 1974; May, 1975; Test, 1979). Such a team might consist either of all case managers, or a case manager and other professionals. In either case, they are collectively responsible for the coordination of their clients. The advantages of a team approach are said to be (Test, 1979):

1. more continuous coverage;

2. better planning with multiple perspectives; and,

3. the avoidance of worker isolation and burn-out.

The appropriateness of an individual or team approach will depend on many factors -- the needs of the client group; the role or role allocations of the case manager; and the case manager's need for a professional identity and association with a team of colleagues. A potential danger of the team approach, however, is that accountability is diffused.

Supervision

Regardless of whether an individual or team approach is used, it is important to provide both support and supervision for case managers to avoid problems associated with worker burn-out (client dependency; feeling of total responsibility; being a generalist, Reagles and Sheets, 1979). The need to provide case managers with a clear identity and a peer group to relate to, is emphasized both in the literature and from our site visits to programs outside the mental retardation field. The supervisor's role becomes a crucial one, not only to insure advocacy and coordination, but also to maintain the case manager's identity and morale.

Caseload

A case manager's caseload is a major determinant of the quality of service provided. With more clients, less time per client is inevitable. There is now evidence that the quality of case mnagement is strongly related to the intensity of contact between the client and case manager (Berkeley Planning Associates, 1977). When caseloads increase to as many as 30 to 50 clients, workers report being more reactive and less proactive, unable to really get to know their clients, relying on clients to contact them, and spending increasing amounts of time documenting their activities (Baker, Intagliata and Kirshstein, 1980). However, if the case manager's role is to coordinate services on a crisis basis, then a higher caseload is possible. One program experimented with case managers providing services to some clients, and only case management to others (Sullivan, undated). However, the roles and skills involved were so different that this approach was abandoned.

Selection and Training of Case Managers

While the specific requirements for a particular case manager's role will determine what characteristics are required for the incumbent, there are some common considerations. Should the case manager be a professional or paraprofessional? In various programs, the educational status of the case managers has varied from high school diplomas (McPheeters, 1974) to doctoral degrees (Altschuler and Forward, 1978). Other programs rely more on past experience in human services than formal education, although both characteristics are positively correlated with effective case management (Berkeley Planning Associates, 1977). Some case management programs exclude applicants who have a strong background in providing specialized services, as their experience has been that such candidates have great difficulty separating the case coordination and direct service components of the case manager's role.

If graduate level training is used as an arbitrary cut-off, most case managers are paraprofessionals. This fact, along with the need for a case manager to be a generalist, has several consequences. In the eyes of many professionals, these characteristics are associated with a lower status, thereby creating a concern about the case manager's credibility. This circumstance speaks to the need for a case management supervisor who is a profesional, who can guide and support the case manager. It also speaks to the need for a clear and formal mandate under which the case manager operates. Again, the linkage of the case manager's role to the broader system's coordinating body is vital (e.g. via a core agency, Intagliata, in press).

A positive consequence of the case manager being a paraprofessional and a generalist, is that they de-emphasize professionalism. They are able to establish rapport with their clients, and operate in ways which would be extremely difficult for professionals (Levine, 1979). In some programs, the case managers are drawn from the client population's community (Weissman, 1978; Dunn, 1979).

The importance of uniform and ongoing training has been stressed (Intagliata, in press) regardless of the case manager's personal or professional characteristics. The many unanswered questions concerning the most effective operation of a case management system requires that workers share a common understanding of the role, and enter the field with some common basic skills. Furthermore, the need to share experiences is heightened by this uncertainty, and opportunities for continuing training have been identified. In fact, a full caseload in the initiation of such a new role is said to interfere with the adequate learning of that role (Amadio, 1979; Baker et al, 1979).

VI. APPLICABILITY OF A CASE MANAGEMENT MODEL

In turning to the issue of applicability, it is helpful to review the major impact of case management systems to date. Awareness of their accomplishments and problems will assist the deliberations concerning future applications.

Impact of Case Management Systems

First of all, it must be said that case management systems have been implemented in a great many jurisdictions (e.g. Gans and Horton, 1975), and with a broad range of clientele. The types of clients served include:

- the elderly (preventing institutionalization)
- welfare recipients
- individuals with alcohol and drug problems
- individuals with mental health problems
- individuals who are mentally retarded, and their families

- o individuals who are developmentaly disabled, and their relatives
- o low income, multi-problem families at risk for child abuse.

The most essential functions performed in all of these programs (Intagliata, in press) regardless of clientele, have been:

1. a focus on the comprehensive needs of clients;
2. linking the clients to services (including an advocacy function); and,
3. monitoring services provided to the client (for the purpose of assessing the appropriateness and effectiveness of the services received).

Evaluations of these case management efforts (Baker and Northman, in press; Caragonne, 1979) indicate that they lead to:

1. increases in accessibility to services;
2. increases in the comprehensiveness of services;
3. increases in the volume of services provided to clients;
4. more effective packaging of client service plans;
5. more effective identification of gaps and duplications in service networks; and,
6. increased organizational responsiveness to consumer needs.

Given these accomplishments, case management systems might reasonably be considered for whatever client populations could benefit from these types of impact.

Despite these accomplishments, it must be noted that solid evidence on the cost-effectiveness of case management systems has not yet been provided. Because more client needs are identified through this approach, more service is provided (Mittenthal, 1976; Morrill, 1976). Consequently, the total costs per client are not necessarily reduced and, in some cases, clearly increase. To our knowledge, no adequate studies have yet been conducted on the longer term cost consequences of this phenomenon. For certain kinds of clients (e.g. the elderly, the retarded or disabled), case management may be required for long periods of time. However, even these clients may increase their level of independence and self-sufficiency so that long-term costs are reduced. For other clients with more acute needs, obtaining appropriate services at the right time might well mean the difference between a life-long dependency on human services, or a dignified level of self-sufficiency. By increasing client self-sufficiency, the case manager's intervention can potentially reduce the staff-client ratio of the service system. Staff costs are, of course, the largest item in the social service budget. A further consideration regarding the efficiency of a case management system is whether only those clients with case managers obtain more service -- at the expense of clients who do not have the benefit of this resource. In any case, the efficiency issues must be viewed not only in absolute dollar costs, but also in terms of how much appropriate service is being provided for those same dollars. In addition, some expenditures may be cost-justified on purely humanitarian grounds, even if cost-effectiveness cannot be demonstrated.

Dimensions to Consider

The above sections outline the various forms the basic case management functions may take. In terms of designing an effective system, the most important determinants of the form a system should take are (Intagliata, in press):

1. the nature of the client population; and,

2. the availability of services for the target group.

There does not appear to be a great deal of literature concerning the specific client characteristics which will affect the design requirements of a case management system. It must also be emphasized that client characteristics are not the only parameter in the design equation. In addition to the availability of services for the target group, issues related to systems linkages, and the legislative, political and fiscal support available, are also crucial. Will there be "core agencies" involved? Will the mandate of the case managers be well publicized -- both to community agencies and client populations? Will the case managers have the authority to monitor and review client progress? or to initiate changes in the way services are delivered? Will the case managers be capable of purchasing services on behalf of clients? How many case managers will be hired? Will the government's commitment to case management endure long enough to make an impact?

Obviously, the answers to these questions with respect to any particular program are complex and will have major consequences for the form the program takes. However, it is still helpful to consider some of the specific client characteristics which are relevant. Such client characteristics include:

1. the potential for self-help - Clients who are physically and mentally capable for self-sufficiency will require services for relatively brief periods of time. They can learn to be good consumers. Other clients will require very long (perhaps life long) support.

2. the multiplicity of needs - Clients with single or few needs might easily be serviced by an information/referral network, with some support and advocacy as required. Other clients with multiple needs will require much more comprehensive and intensive involvement.

3. whether the client is crisis prone - Clients who are likely to require crisis services will require close monitoring during follow-up periods, and strategies will need to be developed which can reduce such incidences.

4. the degree of motivation to accept services - Clients eager for change and assistance are more likely to be able to assist themselves to some degree and take some responsibility for their own status. Clients who are unmotivated will require special strategies to either increase their motivation (at times of crisis?), or to at least maintain contact and rapport over extended periods (Weissman, 1978).

The characteristics of the services to be coordinated which will affect the form of the case management program are:

1. the availability of services - If an area has many overlapping resources, the task of separating them out and rationalizing the system will be different than if resources are scarce and to be developed. For example, case management programs with purchasing power have been found more effective in creating new programs than in changing existing programs (Gans and Horton, 1975; Greater Hartford Process, Inc., 1976).

2. specialized or general services - If the coordination task involves very technical services, a case management team approach may be required (e.g. medical services for the elderly, Quinn, 1975). If very basic life skill resources are to be coordinated, then a simple, case manager generalist is likely to be more appropriate and cost-effective.

3. the professionalism inherent in the services - This dimension of the services to be coordinated has several implications. Highly professionalized service providers may question the credibility and competence of paraprofessional case managers. This may require a strong advocacy mechanism to challenge the professional's 'expertise'. Highly professionalized services will resist any attempts at redefinition or reorganization. This may require strong legislation to redistribute redundant services.

In their review of 30 service integration projects, Gans and Horton (1975) clearly indicate that there is no one, best case management model. The experiences with various models indicate that desirable results are attainable if programs are carefully planned and implemented. With respect to the applicability of a case management model in the area of children's services in Ontario, it would appear that such a model could be developed and extended beyond the Mental Retardation Family Support Program. Indeed, several of the Mental Retardation Family Support Programs reviewed (Applied Research Consulting House, 1982) either had extended the program to include a broader range of clients than was originally intended, or would like to do so.

Expanding the Case Management Potential of Children's Services

While it is beyond the scope of this report to design a case management system for children's services in Ontario, it is helpful to consider what elements of such a system are already in place, and how these components might be expanded or integrated to further the development of the case management functions.

Table 2 presents an overview of the basic dimensions of a case management system and some examples of these elements which are currently operative within the Province. Table 2 is simply meant to outline an approach to reviewing the current status of case management functions in the Province. The examples are not intended to be complete. Also included in the Table are some requirements for expanding the current status of affairs to a more fully developed system.

TABLE 2

EXISTING ELEMENTS OF A CASE MANAGEMENT SYSTEM IN ONTARIO CHILDREN'S SERVICES

DIMENSION	EXAMPLE OF EXISTING ELEMENTS	REQUIREMENTS FOR EXPANDING THE SYSTEM'S CAPABILITIES
o Ideological Base	Program Priorities for Children's Services in 1978 Child Advocacy: Implementing the Child's Right to be Heard (1980)	Further development, publicity and consciousness raising
o Systems Support:		Inter-ministerial policies
- Legislative	Standards for Residential Care (Prime Worker)	Extension of Prime Worker role to areas where it does not exist
- Operational	Children's Services Committees (Regional Offices)	Well publicized guidelines re policy and procedures for case management
o Case Management Functions:		
- Assessment	Multidisciplinary teams in Children's Mental Health Centres, Schedule 1 & 2 Facilities, IPPs* and goal oriented recording	Guidelines for a comprehensive human service needs framework (may be applied by paraprofessionals)
- Planning, Linking, and Monitoring	Probation and Aftercare Officers, some Family Support Workers, some Children's Aid Society activities, some demonstration projects	Identification of an individual to be responsible for these functions, with a clear mandate to do so
o Human Resources	Many qualified individuals who could serve in a generalist role as effective case managers	Development of a Training Program for case managers/ advocates.

* Individualized Program Plan

A quick review of the "Existing Elements" column of the Table indicates that many of the basic components of case management/advocacy already exist. There is a clear ideological base and commitment articulated in the "Program Priorities for Children's Services in 1978". The principles articulated in this document have guided Ministry policy over the past several years, and they incorporate many of the values associated with a consumer-oriented, case management system (Intagliata, in press; Rehab Group Inc., 1980; Gans and Horton, 1975). A recent Ministry Discussion Paper (Child Advocacy, 1980) indicates a further ideological commitment to advocacy. Development in this area is ongoing and publicizing the Ministry's commitment to both the public and professional communities would be helpful. (The Children's Services Newsletter might feature an "Advocate of the Month", highlighting an individual's contribution and generally raising consciousness.)

The system's supports for case management which are currently in place include both legislative and operational examples. The recent publication of "Standards for Residential Care" (1980) for children's services clearly indicate the necessity of a Prime Worker in these facilities. These individuals will have many of the functions of a case manager/advocate, and the fact that they are now required by the Standards, adds some force to their presence. The Probation and Aftercare Officers provide the most complete example of case managers within Ontario's service system for children. However, there are areas of children's services which do not have the types of guidelines or standards which require these functions to be performed.

An expansion of these types of roles, in guidelines or standards to areas where they do not currently exist, would increase the amount of case management which occurs.

An operational support linkage which now exists is the development of Children's Services Committees in various localities. These committees could serve as "core agencies" (President's Commission on Mental Health,

1978), and provide a powerful support system to case management and advocacy activities. The regionalization of children's services Area Offices is yet another operational mechanism that includes some elements of case management. One activity that could make a significant contribution would be the development of guidelines regarding policy and operational procedures for case management advocacy, that applied to each level of operation in the system. These guidelines would have to be well publicized and broadly encouraged, and should address both case and systems advocacy issues.

A further development which would be advantageous is an interministerial policy regarding case management of all human services.

At the actual level of case management functions, there are many examples available in the field. Some examples constitute entire provincial programs (such as the Probation and Aftercare Officers), others are to be found in small demonstration projects (e.g. Parent Resources -funded by the Child Abuse Program of the Ministry of Community and Social Services; Year One Evaluation of Parent Resources Program, Youtec, 1979).

Most elements of the case management function at the worker level are to be found somewhere in the field. However, they are not integrated to create a clear identity or role for the potential case manager. The children's service system in Ontario has a wealth of specialized assessment resources (e.g. in some Children's Mental Health Centres), and all government operated facilities for the developmentally handicapped use some form of IPP or individualized goal recording. However, there is no formal or officially sanctioned framework or resource to conduct a general and comprehensive human needs assessment focusing on basic needs of health, housing, food, employment, etc. Such a needs framework could easily be used by paraprofessionals, reserving the professional resources for more specialized tasks. Guidelines for conducting a comprehensive human needs assessment would be a definite asset to the system (e.g. Department of Human Resources, 1974; John, 1977).

The planning, service linking and monitoring functions of the case manager role are available to some degree in the province. In addition to the Probation and Aftercare Officers already mentioned, and some Family Support Workers, there are also some Children's Aid Society activities that fall into these categories. Generally, however, these functions are not widely available in any systematic way. There is a need to identify specific individuals as responsible for these functions, with a clear mandate to carry them out.

There are many individuals in the children's service field who have the necessary skills and background to be effective case managers. Almost all of the supervisors in the Family Support Worker Evaluation (Applied Research Consulting House, 1982) indicated that their worker recruitment process identified many qualified individuals who would have been suitable for the positions being offered.

The formation of a training program for case managers/advocates would strengthen this human resource pool, and also serve to add further legitimacy, credibility and visibility to the role.

VII. REFERENCES

Agranoff, R., Services Integration, in W.F. Anderson, B.F. Frieden, and M.J. Murphy (Eds.), Managing Human Services, Washington, D.C.: International City Management Association, 1977.

Altschuler, S.C. and Forward, J., The inverted hierarchy: A case manager approach to mental health services, Administration in Health, 1978, 6(1), pp. 57-58.

Amadio, J.B., Integrating Human Services. An Evaluation of the Jackson County Integrated Human Services Delivery Project. Jackson County, Illinois: Jackson County Health Department, 1976.

Applied Research Consulting House Ltd., Evaluation Report: Ontario Family Support Worker Program, prepared for the Ministry of Community and Social Services, Toronto, January, 1982.

Baker, F., Intagliata, J. and Kirshstein, R., Case Management Evaluation: Second Interim Report, Buffalo, N.Y.: Tefco Services, 1980.

Baker, F. and Northman, J.E., Helping: Human Services for the 80's, St. Louis: C.V. Mosby (in press).

Bassuk, E.L. and Gerson, S., Deinstitutionalizatoin and Mental Health Services, Scientific American, 238, pp. 46-53, 1978.

Berkeley Planning Associates, The quality of case management process: Final Report, Vol. III, in U.S. Department of Commerce, National Technical Information Service, The Evaluation of Child Abuse and Neglect Projects 1974-1977, Washington, D.C., 1977.

Caragonne, P., Implications of Case Management: A Report on Research, Presentation at Conference on Case Management, Buffalo, N.Y., April 6, 1979.

Child Advocacy: Implementing the Child's Right to be Heard, Ministry of Community and Social Services, Toronto, Ontario, 1980.

Community Life Association, Hartford SITO Project Documentation. The use of case management and purchase of service contracts in the Community Life Association, Hartford, Connecticut, March, 1974.

Department of Human Resources, D.C. ANACOSTIA Project, Final Report: A Total Package of Integrated Social Rehabilitative Services, Washington, D.C., September, 1974.

Developmentally Disabled Assistance and Bill of Rights Act, Public Law No. 94-103, 42 U.S. Congress, pp. 6001-6081, (Supp. V., 1975).

Division of M.R. Massachusetts Department of Mental Health, Service Coordination Manual, Appendix 4, Copy of Massachusetts Service Coordination Battery/Description of MSCB Contents, Boston, January, 1980.

Dunn, M., The Lower East Side Family Union: Assuring community services for minority families, in S. Maybanks and M. Bryre (eds.), Home-Based Services for Children and Families, Springfield, Illinois: Charles C. Thomas, 1979, 211-224.

Family Support Worker Program Description, Ministry of Community and Social Services, Toronto, Ontario, 1978.

Gans, S.P. and Horton, G.T., Integration of Human Services. The State and Municipal Levels, New York: Praeger, 1975.

General Accounting Office, Returning the mentally disabled to the community: Government needs to do more. Comptroller General's Report to the Congress, Washington, D.C., 1976.

Gittelman, M., Coordinating mental health systems: A national and international perspective, American Journal of Public Health, 1974, 64 pp. 496-500.

Greater Hartford Process, Inc., The Community Life Association from 1972-1975: Final Evaluation Report, Hartford, Connecticut, January, 1976.

Hozen, M. and MacEachron, A.E., Plan evaluation guide: A guide to the planning, management and evaluation of community-based service systems. Toronto, National Institute on Mental Retardation, 1980.

Human Ecology Institute, Inc., An Evaluation of the District V Human Service System, State of Utah, Wellesley, Massachusetts, October, 1975.

Intagliata, J., The history and future of associate degree workers in the human services. In K. Nash, M. Lifton and S. Smith (eds.), The Paraprofessional: Selected Readings. New Haven, Connecticut: Center for Paraprofessional Evaluation and Continuing Education, 1978.

Intagliata, J., Operationalizing a Case Management System: A multi-level approach, Washington, D.C.: National Council on Social Welfare, (in press).

Jessing, B. and Dean, S., Case Advocacy: Ideology and Operation, in L. Baucom and G. Bensberg (eds), Advocacy Systems for Persons with Developmental Disabilities. Lubbock, Texas: Research and Training Center for Mental Retardation, 1976.

John, D., Managing the human service system: What have we learned from services intergration?, Rockville, Maryland: PROJECT SHARE, 1977.

Levine, M., Case Management: Lessons from Earlier Efforts, Evaluation and Program Planning, 1979, 2, 235-243.

Lippman, L., Three examples of case management advocacy. In L. Baucom and G. Bensberg (Eds.), Advocacy systems for persons with developmental disabilities. Lubbock, Texas, Research and Training Center in Mental Retardation, 1976.

May, P., Adopting new models for community care: What are the needs? Hospital and Community Psychiatry, 1975, 26, 599-601.

MacCoy, D., The Community Living Board, Individual Service Contracting: A Pathway to Community Living. Vancouver, unpublished, undated.

McPheeters, H.L., Theme III: Optimal Continuity of Care - Second Faculty Presentation, in Creating the Community Alternative: Options and Innovations. Proceedings of a Conference. Philadelphia, Pa.: Horizon House Institute, March, 1974.

Mittenthal, S., Evaluation Overview: A system approach to services integration, Evaluation, 1976, 3, 142-148.

Mittenthal, S., Clippinger, J., Gotzman, H.J. and Dixon, R., Twenty-Two allied services (SITO) projects described as human services systems. Wellesley, Mass.: Human Ecology Institute, 1974.

Morrill, W., Services Integration and the Department of Health, Education and Welfare, Evaluation, 1976, 3, 52-55.

Patti, R.J., Limitations and Prospects of Internal Advocacy, Social Work, (November) 1974, 9, 537-545.

Pratt, L., Family Structure and Effective Health Behaviour: The Energized Family, Houghton Mifflin Co., Boston, 1976.

President's Commission on Mental Health, Report to the President from the President's Commission on Mental Health, Vol. 1, Washington, D.C.: U.S. Government Printing Office, 1978.

Program Priorities for Children's Services in 1978, Ministry of Community and Social Services, Toronto, Ontario, 1978.

Quinn, J.L., Triage: Coordinated Care for the Elderly, Nursing Outlook, (September) 1975, 23, 570-573.

Rae-Grant, N., Roadblocks and Stopgaps: A Review of Factors Obstructing the Development of Comprehensive Child Mental Health Services, Canadian Psychiatric Association Journal, Vol. 21(6), 1976.

Reagles, S. and Sheets, J., Hutchings Psychiatric Center, Second Year CSP Project Report in S. Steindord (Ed.), Second Year Community Support Progress Report, Albany, N.Y., 1979.

Rehab Group Inc., Design specifications for case management/service coordination and individualized planning, 5827 Columbia Pike, Falls Church, Virginia, 22041, April, 1980.

Report of a U.S. Study Team on Its Visit to England, Scotland and Wales to Observe the Work of Local Authority Social Services, with Implications Noted for the U.S., Toward a Caring Society, N.Y. Columbia School of Social Work, 1974.

Richan, W.C., Dilemnas of the Social Work Advocate, Child Welfare, April 1973, 52(4), 220-225.

Riffer, N. and Freedman, J. Case management in community-based services: A training manual, Albany, N.Y.: New York Office of Mental Health, 1980.

Ross, H., Proceedings of the conference on the evaluation of case management programs (March 5-6, 1979), Los Angeles, California: Volunteers for Services to the Older Persons, 1980.

Standards for Residential Care, Ministry of Community and Social Services, Toronto, Ontario, 1980.

Sullivan, J.P., The Brockton Client Pathway, Brockton, Mass.: Brockton Area Human Resources Group, Inc. (undated).

Test, M., Continuity of Care in Community Treatment, in L. Stein (Ed.), Community Support Systems for the Long-Term Patient, San Francisco: Jossey-Bass, 1979.

Turner, J. and Shiffren, I., Community Support System: How Comprehensive? In L. Stein (Ed.), Community Supporty Systems for the Long-Term Patient, San Francisco, California: Jossey-Bass, Inc., 1979.

Washington, R.O. (Ed.), A Strategy for Services Integration: Case Management, East Cleveland Community Human Service Center, Social and Rehabilitative Services, Department of Health, Education and Welfare, August, 1974.

Washington, R.O., Karmen, M., and Friedlob, A., Second Year Evaluation Report of the East Cleveland Community Human Services Center, Washington, D.C.: Department of Health, Education and Welfare, 1974.

Weissman, H.H., Integrating Services for Troubled Families: Dilemnas of Program Design and Implementation, San Francisco: Jossey-Bass, 1978.

Willer, B., Scheerenberger, R.C., and Intagliata, J., Deinstitutionalization and Mentally Retarded Persons, Community Mental Health Review, 1978, 3, 1-12.

Youtec Consulting, Year One Evaluation on the Parent Resources Program, Toronto, Ontario. (October), 1979.